BRONZE

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible	Participating Providers (In Network)	Non Participating Providers (Out of Network)[1]
Individual	$0	Not Covered
Family	$0	Not Covered

Out of Pocket Information

Out of Pocket Maximum	Participating Providers (In Network)	Non Participating Providers (Out of Network)[1]
Individual	$8,150	Not Covered
Family	$16,300	Not Covered

Schedule of Benefits

The following table represents the medical services currently covered under the EASE BRONZE™ Plan, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

Plan Provisions		Prior Auth Required[2]	Participating Providers (In Network)	Non Participating Providers (Out of Network)
			Member Pays	
PHYSICIAN SERVICES				
Primary Care Office Visit	**(Non-Hospital Based)** (Limited to 8 visits per plan year)	**No**	$25 Copay	Not Covered 100% paid by Member
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Specialist Office Visit	**(Non-Hospital Based)** (Limited to 8 visits per plan year)	**No**	$50 Copay	Not Covered 100% paid by Member
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Urgent Care (Limited to 2 visits per plan year)		**No**	$50 Copay	Not Covered 100% paid by Member
Telemedicine Services		**No**	$0	Not Applicable

[1] If the Plan covers Emergency Room and/or Ambulance Services, those services will be covered if they are provided by an Out of Network provider and will be subject to the deductible and Out of Pocket Maximum.

[2] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.

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Plan Provisions		Prior Auth Required[2]	Participating Providers (In Network)	Non Participating Providers (Out of Network)
			Member Pays	
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services section)	**(Non-Hospital Based)**	**No**	$0 Copay (Plan pays 100% of covered preventive and wellness services)	Not Covered 100% paid by Member
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
HOSPITAL/FACILITY SERVICES (Subject to Referenced Based Pricing)				
Inpatient Hospitalization (Limited to 5 days per plan year)		**Yes**	$350 Copay per admission	
Inpatient Visits - Physician (Limited to visits up to 5 days per plan year)		**No**	Included in Inpatient Hospitalization Copay	
Inpatient Surgery - Physician Charges (Second surgical opinion may be required; Limited to 2 surgeries per plan year)		**Yes**	Included in Inpatient Hospitalization Copay	
Outpatient Hospital or Free Standing Facility Services and Surgery (Limited to 1 visit per plan year)		**Yes**	$350 Copay	
Anesthesia (Limited to 2 inpatient and 1 outpatient anesthetic procedures per plan year)		**No**	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay	
Emergency Room Services (Limited to 1 visit per plan year)		**No**	$350 Copay	
DIAGNOSTIC SERVICES				
Laboratory Services	**(Non-Hospital Based)** (Combined limit of 3 visits per plan year with Radiology)	**No**	$50 Copay	Not Covered 100% paid by Member
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Radiology	**(Non-Hospital Based)** (Combined limit of 3 visits per plan year with Laboratory Services)	**No**	$50 Copay	Not Covered 100% paid by Member
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
CT/MRI/MRA/PET Scan (Limited to 1 visit per plan year.)	**(Non-Hospital Based)**	**Yes**	$350 Copay	Not Covered 100% paid by Member
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member

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Plan Provisions	Prior Auth Required[2]	Participating Providers (In Network)	Non Participating Providers (Out of Network)
		Member Pays	
PREGNANCY BENEFITS			
Professional Services	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Maternity/Childbirth/Delivery	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
OTHER SERVICES			
Allergy Services (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)	No	$25 Copay	Not Covered 100% paid by Member
Home Health Care (Limited to 10 visits per plan year)	No	$25 Copay	Not Covered 100% paid by Member
Treatment for Chemical Abuse & Dependency **(In-Patient)** (Limited to 5 days per plan year)	Yes	$250 Copay per day (Subject to RBP)	
Treatment for Chemical Abuse & Dependency **(Out-Patient)** (Limited to 5 days per plan year)	Yes	$25 Copay per day	Not Covered 100% paid by Member
Rehabilitation/Habilitation Services	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Emergency Medical Transportation (By land only; Limited to 1 transport per plan year)	No	$250 Copay (Subject to RBP)	

PHARMACY BENEFITS		Participating Pharmacies	Non Participating Pharmacies
		Member Pays	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30 day supply		Generic - $0 Copay (Limited to Preventive Generic)	Not Covered 100% paid by Member
Non-Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30 day supply		Not Covered 100% paid by Member	Not Covered 100% paid by Member
Pharmacy Mail Order – 90 day supply		Not Covered 100% paid by Member	Not Covered 100% paid by Member
Preferred Brand, Non Preferred Brand, & Specialty Drugs		Not Covered 100% paid by Member	Not Covered 100% paid by Member

Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:

a. Sports,
b. Camp,
c. Employment,
d. Travel,
e. Insurance,
f. Marriage,
g. Legal proceedings

2. Routine foot care for treatment of the following:

a. Flat feet,
b. Corns,
c. Bunions,
d. Calluses,
e. Toenails,
f. Fallen arches,
g. Weak feet,
h. Chronic foot strain

3. Dental procedures

4. Any other medical service, treatment, or procedure not covered under this Plan

5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by this Appendix A or otherwise explicitly provided in this Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service

6. Claims unrelated to treatment of medical care or treatment

7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition

8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document

9. Any claim related to an injury arising out of or in the course of any employment for wage or profit

10. Claims which would otherwise be covered by a Worker's Compensation policy for which a participant is entitled to benefit

11. Any claim arising from service received outside of the United States, except for the reasonable cost of claims billed by the Veterans Administration or Department of Defense for benefits covered under this Plan and not incurred during or from service in the Armed Forces of the United States

12. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed

13. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted

14. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant

15. Claims due to an act of war, declared or undeclared, not including acts of terrorism

16. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy

17. Abortion Services

18. Travel, unless specifically provided in the schedule of benefits

19. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill

20. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits

21. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials

22. Services or supplies which are primarily educational

23. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression

24. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion

25. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change

Exclusions

26. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant

27. Any claims for fertility or infertility treatment

28. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits

29. Claims for disability resulting from reversal of sterilization

30. Claims for the completion of forms, or failure to keep scheduled appointments

31. Recreational or diversional therapy

32. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider

33. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding

34. Claims that arise primarily due to medical tourism

35. Supportive devices of the foot

36. Treatments for sexual dysfunction

37. Aquatic or massage therapy

38. Biofeedback training

39. Skilled nursing facilities

40. Durable medical equipment and prosthetics

41. Hospice care, private duty nursing, or long-term care

42. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury

43. Claims for temporomandibular joint syndrome

44. Claims for biotech or specialty prescriptions

45. Any claim which is not explicitly covered in the schedule of benefits

46. Genetic testing unless explicitly covered in the schedule of benefits

47. Organ transplants

48. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.

49. Chiropractic care

50. Radiation and chemotherapy

51. Dialysis

52. Acupuncture

53. Alternative medicine/homeopathy

54. Children dental and vision

55. Neonatal intensive care (NICU)

56. Rehabilitative therapies

57. PCP surgery

58. Routine eye care (Adult)

59. Non-emergency care when traveling outside the U.S.

60. Pregnancy Benefits, including office visits and childbirth/delivery professional and facility services.

61. Routine well-baby care of newborn infant while inpatient.

“The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.”